ABORTION:

ITS IMMEDIATE AND REMOTE EFFECTS WITH REFERENCE TO TREATMENT

BY

W. P. MANTON, M. D.

President of the Detroit Academy of Medicine; Lecturer on Obstetrics, Detroit College of Medicine, Etc.

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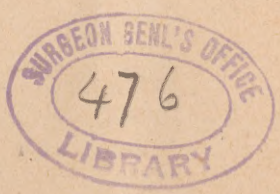

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SO familiar have we become with the term abortion, and so apprehensive are we of the immediate effects of this condition, that the remote states which may arise as sequelæ of the premature extrusion of the ovum are very apt to be lost sight of. We congratulate ourselves if our patient escapes death from hæmorrhage, but forget that the severe bleeding which may have gone on for some time unchecked may induce a condition of chronic anæmia, which not only is difficult to cure, but to which perhaps the patient may ultimately succumb. Or, the terrors of sapræmia and septicæmia having been in the first instance obviated, the secondary effects, mild endometritis, metritis, tubal and peritoneal disease, are immediately out of memory. To one familiar with the natural history of pelvic disease, the casting of the immature öosperm must always be looked upon as a serious affair, dangerous in its direct effects, and perilous in its remote developments.

Modern methods in the treatment of this class of cases, however, have removed much of the danger which surrounds this unfortunate condition, and the antiseptic system, in this as in all other departments of midwifery, must be credited with having brought about a revolution in methods.

In the few remarks which I shall offer for your attention, I desire to confine myself almost entirely to the consideration of the best methods of treatment in cases of certain abortion, especially with reference to the immediate and remote effects. Given a case of partial or

complete detachment of the chorion or placenta, with a still hard, unyielding cervix uteri, how shall we proceed? Obviously, the first indication is to stop the hæmorrhage, not because it is alarmingly profuse, perhaps, but because the constant bloody stillicidium may so far reduce the patient's powers of restitution, or result in such vaso-motor changes, as to give rise to immediate flooding or remote anæmia. The old-fashioned way to stop a hæmorrhage was to administer astringents, but it was also known that these, in the majority of cases, are quite inefficient in controlling the hæmorrhage due to abortion. This naturally led to the employment of the tampon, and numerous and varied have been the devices suggested for this purpose. Perhaps the most universally employed tampon has been the so-called kite-tail, a series of cotton balls tied in a row to a string, each ball being inserted into the vagina through a speculum, and packed tightly. This tampon is perhaps sufficiently useful to be retained in our list of methods, but it does not always stop the bleeding, which may run through the interstices between the cotton wads. The next method of tamponing the vagina, a method which is almost absolutely perfect as far as controlling the blood is concerned, is that of which I have already written in regard to the treatment of prolapsed ovaries and utero-pelvic adhesions. The small caramel-like squares of cotton, which have previously been wrung out in glycerin water, are carefully packed around and over the cervix until the vagina is well filled. It is a good plan to soak the upper pieces of tampon in strong alum water, in order to produce an astringent effect upon the upper portion of the vagina. Such a tampon is almost impervious, the upper pieces of

cotton absorbing the blood, which coagulates in their meshes, thus furnishing a barrier to further escape, while the whole packing by its pressure lessens the blood supply to the part and favors coagulation in the vessels.

After a somewhat extensive experience with this method, I have seen but one or two instances in which this tampon, when properly applied, did not completely control the hæmorrhage.

The objections to the two methods just given are, in the first, that the size of the tampon frequently renders its insertion intolerable to the patient, who is already nervous, apprehensive, and suffering, while it is often quite inefficient in controlling the blood flow. In the second method the tampons can only be placed successfully with the patient on the side and a Sims speculum distending the vagina, thus necessitating an assistant, who is not always to be had, while the number of cotton squares packed in renders their removal by anyone but the physician impossible. Again, neither of these methods hastens the dilatation of the uterine neck with the rapidity and thoroughness desirable.

The objection to Barnes' bags and the balloon of Champetier, for this purpose, is the difficulty of maintaining asepsis. The same may be said of the sponge tent—one of the most dangerous and unsatisfactory methods of dilatation, and which, fortunately, is fast falling into disuse. The dilators of Ellinger, Goodell and others are frequently employed for this purpose, and often of necessity in cases where the uterine neck is still hard and unyielding, and immediate removal of the products of conception becomes imperative. This state

of affairs is, however, of comparative infrequence. In general, instruments for forcible widening of the parts are unnecessary.

The ideal method in the treatment of these cases, I am convinced after repeated trials, is that introduced by Duhrssen for the control of post-partum hæmorrhage, and afterwards recommended by Chenevière for inducing artificial abortion. This method is simple, effectual, and thoroughly antiseptic. The *modus operandi* is as follows: With the patient on the cross bed, and the legs flexed and widely separated, a bivalve speculum is introduced, and the vagina thoroughly cleansed of all clots and blood. This may be effected either by means of a warm antiseptic douche, or by swabs of antiseptic cotton. The uterine neck is then steadied by a tenaculum, bullet forceps, or vulsellum, and a strip of antiseptic gauze half an inch wide and from one to three feet long, according to the case, is carried into the cervical canal by means of an instrument resembling an applicator. The entire strip of gauze, excepting the last two inches, is then packed into the cervical canal. Some force is occasionally necessary in order to get the gauze into the canal, but as a rule it causes the patient but little pain or discomfort. Another strip of gauze, two inches wide and a yard long, is then firmly packed into the vagina, and the process is finished.

Either bichloride or iodoform gauze may be used; I prefer the latter on account of its slight hæmostatic qualities.

Any subsequent pain due to uterine contractions should be controlled by opiates—morphine with atropia, in my hands, proving the most satisfactory.

The antiseptic gauze tampon may be left in the vagina for twenty-four hours, or longer if necessary, although repacking is desirable, at the end of which time it may be removed as one removes a string from a twine-holder. The cervix uteri will be found soft and dilatable, readily admitting one or two fingers. In many cases, when the gauze is removed, the entire ovum will be found lying on its upper layers or free in the posterior *cul de sac*. The remaining treatment consists in douching out the vagina with an antiseptic lotion, rest in bed, and the administration of ergot (or a mixture of ergot, hydrastis, and tr. cinnamon) for a few days. If the case is first seen when the abortion is considerably advanced, the cervix being already dilated, but the ovum still in utero, or if after the packing the ovum still adheres to the uterine wall, a different method of procedure is indicated.

Formerly the expectant method—that is, the administration of ergot, and patient waiting—was in vogue. This is obviously bad practice, for two reasons: It exposes the patient to the liability of severe hæmorrhage, often amounting to flooding, and in many instances to the dangers of sapræmia or septicæmia from the absorption of decomposing, perhaps putrid, matter from the uterine interior. In dealing with such a case, modern antiseptic midwifery teaches but one method of procedure, the immediate emptying of the uterus.

This may be effected in two ways: 1st, by the finger of the physician; 2d, by the use of instruments; but preferably by a combination of both fingers and instruments. Frequently the finger alone is sufficient to dislodge the ovum or placenta, but usually, and especially

in the early months of pregnancy, instrumental interference will be required.

For removing retained deciduæ, or placental remains, I prefer the sharp curette of Thomas and the admirable little forceps devised by our colleague, Dr. Longyear. The patient is placed on the cross bed, the bivalve speculum introduced, the vagina thoroughly cleansed, the uterus thoroughly but gently scraped clean of its contents. An intra-uterine douche of carbolic or creolin is then given, the vagina packed with iodoform gauze as described, and the patient left in peace and comfort, with nothing to fear from subsequent hæmorrhage or inflammation.

In all of these manipulations the *sine qua non* of success is absolute cleanliness; it is undoubtedly due to the neglect of this that subsequent septic inflammatory conditions of the endometrium occur, which retard involution and may lead to serious tubal disease.

The physician's hands should be strictly clean—washed in soap and water, scrubbed with a nail-brush, the finger-nails freed from adhering dirt, and again washed in bichloride solution. The instruments employed should be clean and placed in an antiseptic lotion or in boiling water which is gradually allowed to cool to the desired temperature. And, lastly, the vagina should be clean, by douching or swabbing.

Such, in brief, is the modern method of treating this formidable class of cases, inevitable abortion; thus handled, the primary dangers are avoided, and the secondary evils need never be entailed upon already overburdened womanhood.

83 Lafayette Ave.